		FOR OHF USE					

LL1

2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0026765

Facility Name: Burgin Manor of Olney, Inc.

Address: 928 East Scott (Number) Olney (City) 62450 (Zip Code)

County: Richland

Telephone Number: 618-395-1000 **Fax #** 618-392-2150

IDPA ID Number: 37-1116643001

Date of Initial License for Current Owners: 4/20/82

Type of Ownership:

	VOLUNTARY,NON-PROFIT	x	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		x	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Karl Baker **Telephone Number:** 314-231-5544

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 01/01/02 to 12/31/02 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) _____
(Title) _____

Paid Preparer
(Signed) _____ (Date)
(Print Name and Title) _____
(Firm Name & Address) _____
(Telephone) ( ) Fax # ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	153	Skilled (SNF)	153	55,845	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	153	TOTALS	153	55,845	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26,923	22,046	1,150	50,119	8
9	SNF/PED					9
10	ICF					10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	26,923	22,046	1,150	50,119	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 89.75%

D. How many bed-hold days during this year were paid by Public Aid?
141 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [ ] NO [x]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [x]

I. On what date did you start providing long term care at this location?
Date started 4/20/82

J. Was the facility purchased or leased after January 1, 1978?
YES [x] Date 4/20/82 NO [ ]

K. Was the facility certified for Medicare during the reporting year?
YES [x] NO [ ] If YES, enter number of beds certified 16 and days of care provided 1,150

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [x] NO [ ]

Tax Year: 12/31/02 Fiscal Year: 12/31/02

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	252,710	20,856	12,346	285,912	5,140	291,052		291,052			1
2	Food Purchase		246,542		246,542	(5,681)	240,861		240,861			2
3	Housekeeping	97,606	23,708		121,314		121,314		121,314			3
4	Laundry	77,790	8,974	3,030	89,794		89,794		89,794			4
5	Heat and Other Utilities			102,972	102,972		102,972		102,972			5
6	Maintenance	45,078	14,636	68,344	128,058		128,058	133	128,191			6
7	Other (specify):*											7
8	**TOTAL General Services**	473,184	314,716	186,692	974,592	(541)	974,051	133	974,184			8
	B. Health Care and Programs											
9	Medical Director			6,000	6,000		6,000		6,000			9
10	Nursing and Medical Records	1,562,315	128,865	58,109	1,749,289	5,140	1,754,429		1,754,429			10
10a	Therapy	42,900	3,459	120,948	167,307		167,307		167,307			10a
11	Activities											11
12	Social Services	123,569	3,156	7,097	133,822		133,822		133,822			12
13	Nurse Aide Training											13
14	Program Transportation											14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	1,728,784	135,480	192,154	2,056,418	5,140	2,061,558		2,061,558			16
	C. General Administration											
17	Administrative	97,850		146,057	243,907	41,553	285,460	(59,798)	225,662			17
18	Directors Fees											18
19	Professional Services			42,172	42,172		42,172	88,792	130,964			19
20	Dues, Fees, Subscriptions & Promotions			12,338	12,338		12,338	(176)	12,162			20
21	Clerical & General Office Expenses	124,968	10,424	57,184	192,576	(39,837)	152,739	15,681	168,420			21
22	Employee Benefits & Payroll Taxes			731,983	731,983	5,681	737,664	20,291	757,955			22
23	Inservice Training & Education			4,538	4,538		4,538		4,538			23
24	Travel and Seminar			2,116	2,116		2,116		2,116			24
25	Other Admin. Staff Transportation			11,424	11,424		11,424		11,424			25
26	Insurance-Prop.Liab.Malpractice			100,751	100,751		100,751		100,751			26
27	Other (specify):*											27
28	**TOTAL General Administration**	222,818	10,424	1,108,563	1,341,805	7,397	1,349,202	64,790	1,413,992			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	2,424,786	460,620	1,487,409	4,372,815	11,996	4,384,811	64,923	4,449,734			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Burgin Manor of Olney, Inc. #0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation			118,727	118,727		118,727	51,661	170,388			30
31	Amortization of Pre-Op. & Org.			1,248	1,248		1,248		1,248			31
32	Interest			178,856	178,856		178,856	(15,667)	163,189			32
33	Real Estate Taxes			78,300	78,300		78,300		78,300			33
34	Rent-Facility & Grounds							8,153	8,153			34
35	Rent-Equipment & Vehicles			16,610	16,610		16,610		16,610			35
36	Other (specify):*											36
37	**TOTAL Ownership**			393,741	393,741		393,741	44,147	437,888			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		3,001		3,001	5,140	8,141		8,141			39
40	Barber and Beauty Shops			22,736	22,736		22,736		22,736			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			83,767	83,767		83,767		83,767			42
43	Other (specify):*			98,874	98,874	(17,136)	81,738	(88,770)	(7,032)			43
44	**TOTAL Special Cost Centers**		3,001	205,377	208,378	(11,996)	196,382	(88,770)	107,612			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	2,424,786	463,621	2,086,527	4,974,934		4,974,934	20,300	4,995,234			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms	(2,487)	43		5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	50,814	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(3,292)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)	(8,001)	43		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(38,827)	43		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(57,739)			29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (59,532)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)	79,832		34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 79,832		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,300		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.			$		38
39						39
40	Gift and Coffee Shops					40
41	Barber and Beauty Shops					41
42	Laboratory and Radiology					42
43	Prescription Drugs					43
44	Exceptional Care Program					44
45	Other-Attach Schedule					45
46	Other-Attach Schedule					46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

STATE OF ILLINOIS

Burgin Manor of Olney, Inc.

ID# 0026765

Report Period Beginning: 01/01/02

Ending: 12/31/02

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	Lobbying Expenses	$ (734)	20	1
2	Offset Interest Income	(19,713)	32	2
3	Offset Vendeing Machine Income	(4,755)	43	3
4	Offset Telephone Income	(1,129)	21	4
5	Newscoop	(11,197)	43	5
6	Public Relations	(4,215)	43	6
7	Golden Friendship	(899)	43	7
8	Resident/Family Relations	(3,764)	43	8
9	Corporate Taxes	(404)	43	9
10	Other Marketing Expense	(16)	43	10
11	Transfer Insurance	(10,913)	43	11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(57,739)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	133	0	0	0	0	0	0	0	0	0	133	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	133	0	0	0	0	0	0	0	0	0	133	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	(59,798)	0	0	0	0	0	0	0	0	0	(59,798)	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	88,792	0	0	0	0	0	0	0	0	0	88,792	19
20	Fees, Subscriptions & Promotions	(734)	558	0	0	0	0	0	0	0	0	0	(176)	20
21	Clerical & General Office Expenses	(1,129)	16,810	0	0	0	0	0	0	0	0	0	15,681	21
22	Employee Benefits & Payroll Taxes	0	20,291	0	0	0	0	0	0	0	0	0	20,291	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(1,863)	66,653	0	0	0	0	0	0	0	0	0	64,790	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(1,863)	66,786	0	0	0	0	0	0	0	0	0	64,923	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	50,814	847	0	0	0	0	0	0	0	0	0	51,661	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	(19,713)	4,046	0	0	0	0	0	0	0	0	0	(15,667)	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,153	0	0	0	0	0	0	0	0	0	8,153	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	31,101	13,046	0	0	0	0	0	0	0	0	0	44,147	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(88,770)	0	0	0	0	0	0	0	0	0	0	(88,770)	43
44	**TOTAL Special Cost Centers**	(88,770)	0	0	0	0	0	0	0	0	0	0	(88,770)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(59,532)	79,832	0	0	0	0	0	0	0	0	0	20,300	45

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
Jerold Axelbaum	30.58			Burgin Health		
Shirley Axelbaum	30.58			Management, Inc	University City, Mo	Management Co.
Steven Axelbaum	9.71					
Bruce Axelbaum	9.71					
Richard Axelbaum	9.71					
David Axelbaum	9.71					

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [x] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	17	Consulting Fees	$ 146,057	Burgin Health Management, Inc.	**	$	$ (146,057)	1
2	V	6	Repairs & Maintenance		Burgin Health Management, Inc.	**	133	133	2
3	V	19	Professional Fees		Burgin Health Management, Inc.	**	88,792	88,792	3
4	V	20	Taxes & Licenses		Burgin Health Management, Inc.	**	558	558	4
5	V	21	Clerical Expense		Burgin Health Management, Inc.	**	16,810	16,810	5
6	V	22	Employee Benefits		Burgin Health Management, Inc.	**	13,873	13,873	6
7	V	22	Insurance		Burgin Health Management, Inc.	**	6,418	6,418	7
8	V	24	Seminars & Travel		Burgin Health Management, Inc.	**			8
9	V	30	Depreciation		Burgin Health Management, Inc.	**	847	847	9
10	V	32	Interest		Burgin Health Management, Inc.	**	4,046	4,046	10
11	V	34	Rent		Burgin Health Management, Inc.	**	8,153	8,153	11
12	V	17	Salaries		Burgin Health Management, Inc.	**	86,259	86,259	12
13	V								13
14	Total			$ 146,057			$ 225,889	$ * 79,832	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Jerold Axelbaum	President	Administrative	50.00		40	100.00	Wages	$ 39,826		1
2	Shirley Axelbaum	Vice President	Supervisory	50.00		40	100.00	Wages	10,282		2
3	Steve Axelbaum	Oper. Supervisor	Administrative			40	100.00	Wages	82,584		3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 132,692		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [x] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Burgin Health Management
Street Address: 8220 Delmar
City / State / Zip Code: University City, MO
Phone Number: (314) 692-0777
Fax Number: (314) 392-0406

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	6	Repairs & Maintenance	Costs	5,284,841	1	$ 147	$	4,787,329	$ 133	1
2	19	Professional Fees	Costs	5,284,841	1	98,020		4,787,329	88,792	2
3	20	Taxes & Licenses	Costs	5,284,841	1	616		4,787,329	558	3
4	21	Clerical Expense	Costs	5,284,841	1	18,557		4,787,329	16,810	4
5	22	Employee Benefits	Salary Allocation		1	21,341			13,873	5
6	24	Seminars & Travel	Costs	5,284,841	1			4,787,329	0	6
7	25	Auto Expense	Costs	5,284,841	1			4,787,329	0	7
8	30	Depreciation	Costs	5,284,841	1	935		4,787,329	847	8
9	32	Interest	Costs	5,284,841	1	4,467		4,787,329	4,046	9
10	34	Rent	Costs	5,284,841	1	9,000		4,787,329	8,153	10
11	17	Jerold Axelbaum - Wages	Direct		1				39,826	11
12	17	Shirley Axelbaum - Wages	Direct		1				5,141	12
13	17	Steve Axelbaum - Wages	Direct		1				41,292	13
14	22	Insurance	Costs	5,284,841	1	7,085		4,787,329	6,418	14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 160,168	$		$ 225,889	25

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1	U.S. Bank		x	Mortgage	$3,100 + int.	10/4/02	$ 2,245,000	$ 2,235,700	10/4/07	libor+2.5%	$ 22,943	1
2	Illinois Community Bank		x	Telephone System	$723.00	4/7/99	35,014		3/7/04	9.4590	1,056	2
3	First National Bank of Olney		x	Vehicle	$784.00	3/1/00	37,830		3/1/05	8.7500	1,679	3
4	First National Bank of Olney		x	Renovations	$3,047.00	2/9/00	250,000		2/9/10	8.1000	14,287	4
5	See Attachment		x	Various	Various	Various	2,615,700		Various	Various	117,474	5
	Working Capital											
6	U.S. Bank		x	Operating	Interest	10/4/02	494,925	494,925	10/04/07	libor+2.5%	4,961	6
7	First National Bank of Olney		x	Sweep Acct. Operating		12/8/01	600,000		12/8/02	1% over WSJ	13,782	7
8	See Attachment		x	Various	Various	Various	40,000		Various	Various	2,674	8
9	TOTAL Facility Related				$4,554.00		$ 6,318,469	$ 2,730,625			$ 178,856	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$ 6,318,469	$ 2,730,625			$ 178,856	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ _____ Line # _____

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)**

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2001 report.	$	75,966	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	77,133	2
3. Under or (over) accrual (line 2 minus line 1).	$	1,167	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)	$	77,133	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**	$		5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**	$		6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	78,300	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:

1997	65,692	8
1998	69,403	9
1999	74,315	10
2000	75,966	11
2001	77,133	12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

Accrual for 2002 Taxes = 77133

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2001 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2001 real estate tax costs, as well as copies of your real estate tax bills for calendar 2001.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2001 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2002 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2001 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Burgin Manor of Olney, Inc. COUNTY Richland

FACILITY IDPH LICENSE NUMBER 0026765

CONTACT PERSON REGARDING THIS REPORT Ms. Sue Burgin

TELEPHONE 618-395-1000 FAX #: 618-392-2150

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2001 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2001.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	1-06-35-350-002	See Attached	$ 77,132.68	$ 77,132.68
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 77,132.68	$ 77,132.68

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES x NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2001 tax bills which were listed in Section A to this statement. Be sure to use the 2001 tax bill which is normally paid during 2002.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 41,617 B. General Construction Type: Exterior Brick Frame Wood Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

N/A

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized:

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident Care	234,725	1982	$ 75,000	1
2					2
3	TOTALS	234,725		$ 75,000	3

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4			1982	1892	$ 1,510,000	$	28	$ 53,929	$ 53,929	$ 1,107,431	4
5			1996	1996	826,743	21,199	39	33,070	11,871	202,954	5
6											6
7											7
8											8
	Improvement Type**										
9	Land Improvements			1985	557		10			557	9
10	Land Improvements			1987	21,035		10			21,035	10
11	Land Improvements			1991	622	36	15	41	5	387	11
12	Landscaping			1992	1,112	66	15	74	8	1,019	12
13	Asphalt Repairs			1995	455	29	10		(29)	455	13
14	Courtyard Improvements			1996	1,533	253	7	219	(34)	932	14
15	Additions			1983	35,819		10			35,819	15
16	Additions			1984	30,212		10			30,212	16
17	Additions			1985	14,744		10			14,744	17
18	Additions			1986	24,917		19			24,917	18
19	Additions			1987	16,810		10			16,810	19
20	Additions			1988	387		10			387	20
21	Additions			1989	10,163		10			10,163	21
22	Additions			1990	12,277		10			12,277	22
23	Additions			1991	28,943	919	31	934	15	15,103	23
24	Additions			1992	3,542	112	31	114	2	1,581	24
25	Additions			1993	51,504	1,398	Various	1,408	10	38,976	25
26	Additions			1994	36,243	1,188	Various	2,691	1,503	22,253	26
27	Additions			1994	4,406	11	Various	227	216	1,781	27
28	Additions			1995	7,326	73	Various	619	546	4,549	28
29	Additions			1996	87,605	7,524	Various	12,174	4,650	67,382	29
30	Landscaping			1997	2,287	140	15	152	12	1,009	30
31	Entrance Drive			1997	8,461	519	15	564	45	3,455	31
32	Lighting			1997	739	63	7	106	43	503	32
33	Fire Alarm			1997	1,316	112	7	188	76	893	33
34	Beds (used to say Sprinkler)			1997	30,726	2,612	7	4,389	1,777	20,849	34
35	Soffit			1998	16,899	433	39	433		1,511	35
36	Fencing			1998	15,209	1,036	15	1,014		3,548	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	Landscaping	1998	$ 1,292	$ 88	15	$ 86	$ (2)	$ 280	37
38	Parking Lot	1998	23,912	1,628	15	1,594	(34)	5,778	38
39	Lighting-West Bldg	1998	1,085	28	39	28		106	39
40	Lighting-East Bldg	1998	701	18	39	18		78	40
41	Ceiling-East Hall	1998	1,670	43	39	43		157	41
42	Carpet	1998	498	59	7	71	12	181	42
43	Door Closers	1998	1,062	90	7	152	62	275	43
44	Lighting Improvements	1998	9,850	253	39	253		1,005	44
45	Carpet	1999	296	38	7	42	4	204	45
46	Hubl & Ratchet Cutter	1999	1,129		10	113	113	405	46
47	Carpet	1999	888	113	7	127	14	587	47
48	Sprinklers	1999	1,079		7	154	154	539	48
49	Sprinklers	1999	477		7	68	68	232	49
50	Electric Quick Serve	1999	435		10	44	44	154	50
51	Ceiling-West nurse's station	1999	531	14	39	14		128	51
52	Ceiling- Aspen	1999	1,221	31	39	31		286	52
53	Breezeway Soffit, facia, and gutters	1999	1,435		15	96	96	312	53
54	Sidewalks	1999	10,278	796	15	685	(111)	2,341	54
55	Driveway	1999	19,536	1,516	15	1,302	(214)	4,232	55
56	Gutter	1999	(220)		15			30	56
57	Soffit	1999	(1,215)		15			162	57
58	Tools	1999	(435)		10			88	58
59	Ratchet Cutter	1999	(1,129)		10			226	59
60	Dry Pendant Sprinklers	1999	(1,556)		7			444	60
61	Concrete Pad for Dumpster Site	2000	906	77	15	60	(17)	180	61
62	Lamps	2000	5,502	962	7	786	(176)	1,886	62
63	Electrical Fixtures	2000	3,761	658	7	537	(121)	1,289	63
64	Alarm System	2000	10,261	1,795	7	1,466	(329)	3,518	64
65	Overbed Tables	2000	5,670	992	7	810	(182)	1,755	65
66	4 Drawer Cabinets	2000	19,256	3,368	7	2,751	(617)	5,319	66
67	Drapes, Valances, Bedspreads	2000	23,184	4,056	7	3,312	(744)	12,586	67
68	Sidewalks	2000	14,236	1,217	15	949	(268)	4,509	68
69	Chairs	2000	11,939	2,088	7	1,706	(382)	4,094	69
70	TOTAL (lines 4 thru 69)		$ 2,970,127	$ 57,651		$ 129,644	$ 72,015	$ 1,716,857	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 2,970,127	$ 57,651		$ 129,644	$ 71,993	$ 1,716,857	1
2	Remodeling	2000	8,255	1,444	7	1,179	(265)	2,279	2
3	Corner Protectors & Kick Plates	2000	2,873	287	10	287		861	3
4	Painting	2000	11,260	2,252	5	2,252		6,756	4
5	Floor Tiling	2000	3,799	665	7	543	(122)	923	5
6	Wallpaper	2000	10,972	2,194	5	2,194		6,582	6
7	3 Ceiling Fans	2001	1,359	49	27	50	1	100	7
8	Architectural Services	2001	12,131	441	27	449	8	899	8
9	Drywalling	2001	919	33	27	34	1	68	9
10	2 bedrooms converted to dining room	2001	1,103	40	27	41	1	82	10
11	Drapery Liners & Hardware	2001	2,856	699	7	408	(291)	816	11
12	Floor Tiling	2001	11,118	2,723	7	1,588	(1,135)	3,176	12
13	Magnetic Lock & Key Pad	2001	2,872	704	7	410	(294)	820	13
14	2 60 lb. Washers	2001	13,630		7	1,947	1,947	3,894	14
15	Toilets & Lavatory	2001	1,281	149	7	183	34	366	15
16	Alarm System	2001	5,903		7	843	843	1,686	16
17	2 Boilers for Furnace	2001	16,508	4,043	7	2,358	(1,685)	4,716	17
18	Doors for Aspen Wing	2001	981	240	7	140	(100)	280	18
19	Air Handler	2002	2,096	299	7	299		299	19
20	Smoke Detector	2002	1,440	206	7	206		206	20
21	Bathroom Flooring	2002	255	1	27	1	(0)	1	21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 3,081,738	$ 74,120		$ 145,056	$ 70,936	$ 1,751,667	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 510,932	$ 25,319	$	$ (25,319)		$	71
72	Current Year Purchases	63,444	8,217	9,063	846	7		72
73	Fully Depreciated Assets	418,556						73
74								74
75	TOTALS	$ 992,932	$ 33,536	$ 9,063	$ (24,473)		$	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Residental Care	1992 Ford Ranger	1996	$ 3,780	$	$	$	5	$ 3,780	76
77	Facility Use	1993 Dodge	1997	3,000	161	400	239	5	3,000	77
78	Facility Use	2000 Ford Van	2000	42,810	2,950	8,562	5,612	5	10,910	78
79	Facility Use	1998 Toyota Avalon	2001	17,000	4,900	3,400	(1,500)	5	6,800	79
80	TOTALS			$ 66,590	$ 8,011	$ 12,362	$ 4,351		$ 24,490	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 4,216,260	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 115,667	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 166,481	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 50,814	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,776,157	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1999 Infiniti I-30 Aquired in 2002	$ 19,833	$ 3,060	$ 3,967	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 19,833	$ 3,060	$ 3,967	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. [ ] YES [ ] NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: [ ] YES [ ] NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? [ ] YES [x] NO

16. Rental Amount for movable equipment: $ 13,887 Description: Dshwshr-1140;IVAC Pump-300;Oxygen Concentra.-9772;Air Beds-2635;Projector-5;Concrete Saw-35
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD?
   - [ ] YES
   - [x] NO

   If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER AIDE ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER AIDE ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2		3	4		5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$	1,723	$	45,000	$ 2,992	1,723	$ 47,992	1
2	Licensed Speech and Language Development Therapist		hrs		614		18,906		614	18,906	2
3	Licensed Recreational Therapist		hrs								3
4	Licensed Physical Therapist		hrs		1,830		57,042	467	1,830	57,509	4
5	Physician Care		visits								5
6	Dental Care		visits								6
7	Work Related Program		hrs								7
8	Habilitation		hrs								8
9	Pharmacy		# of prescrpts								9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs								10
11	Academic Education		hrs								11
12	Exceptional Care Program										12
13	Other (specify):										13
14	TOTAL			$	4,167	$	120,948	$ 3,459	4,167	$ 124,407	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Burgin Manor of Olney, Inc. **#** 0026765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 12/31/02 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 50,149	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	589,070		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments			5
6	Prepaid Insurance	33,404		6
7	Other Prepaid Expenses	35,539		7
8	Accounts Receivable (owners or related parties)	386,271		8
9	Other(specify):			9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 1,094,433	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	75,000		13
14	Buildings, at Historical Cost	2,999,111		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	1,080,324		16
17	Accumulated Depreciation (book methods)	(2,972,182)		17
18	Deferred Charges	183,870		18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 1,366,123	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,460,556	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 145,926	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	2,235,700		29
30	Accrued Salaries Payable	85,773		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	77,133		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Other Liabilities	28,897		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 2,573,429	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable	497,728		39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$ 497,728	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 3,071,157	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ (610,601)	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,460,556	$	48

***(See instructions.)**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ (807,584)	1
2	Restatements (describe):		2
3	**Prior Period Adjustment**	197,278	3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ (610,306)	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(295)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ (295)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ (610,601)	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 5,230,363	1
2	Discounts and Allowances for all Levels	(701,789)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 4,528,574	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	156,330	6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$ 156,330	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	19,941	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio	2,487	15
16	Rental of Facility Space		16
17	Sale of Drugs	61,025	17
18	Sale of Supplies to Non-Patients		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	81,678	21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 165,131	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***	19,714	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 19,714	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	See Attached Schedule	63,342	28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 63,342	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 4,933,091	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	974,591	31
32	Health Care	2,056,418	32
33	General Administration	1,301,506	33
	B. Capital Expense		
34	Ownership	392,493	34
	C. Ancillary Expense		
35	Special Cost Centers	124,611	35
36	Provider Participation Fee	83,767	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 4,933,386	40
41	**Income before Income Taxes (line 30 minus line 40)****	(295)	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ (295)	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? _____ If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,082	2,282	$ 48,558	$ 21.28	1
2	Assistant Director of Nursing	2,006	2,155	42,655	19.79	2
3	Registered Nurses	25,080	26,911	429,779	15.97	3
4	Licensed Practical Nurses	16,069	17,120	232,386	13.57	4
5	Nurse Aides & Orderlies	96,548	100,902	818,007	8.11	5
6	Nurse Aide Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,348	4,546	42,304	9.31	8
9	Activity Director	2,075	2,157	23,437	10.87	9
10	Activity Assistants	9,938	10,281	66,384	6.46	10
11	Social Service Workers	3,861	3,937	31,284	7.95	11
12	Dietician					12
13	Food Service Supervisor	2,260	2,465	29,851	12.11	13
14	Head Cook	5,869	6,156	49,102	7.98	14
15	Cook Helpers/Assistants	20,335	21,032	130,508	6.21	15
16	Dishwashers					16
17	Maintenance Workers	3,721	4,042	46,541	11.51	17
18	Housekeepers	14,039	14,651	96,408	6.58	18
19	Laundry	11,279	11,613	75,661	6.52	19
20	Administrator	2,381	2,509	63,344	25.25	20
21	Assistant Administrator	1,895	2,086	28,085	13.46	21
22	Other Administrative					22
23	Office Manager	2,031	2,283	37,440	16.40	23
24	Clerical	2,219	2,348	26,797	11.41	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	2,139	2,410	24,415	10.13	31
32	Other Health Care(specify)					32
33	Other(specify) Dietary Aides	6,220	6,348	40,286	6.35	33
34	TOTAL (lines 1 - 33)	236,395	248,234	$ 2,383,232 *	$ 9.60	34

* This total must agree with page 4, column 1, line 45. ** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	198	$ 9,841	Line 1(3)	35
36	Medical Director	Monthly	6,000	Line 9(3)	36
37	Medical Records Consultant	Monthly	775	Line 10(3)	37
38	Nurse Consultant				38
39	Pharmacist Consultant	Monthly	1,800	Line 10(3)	39
40	Physical Therapy Consultant	114	5,119	Line 10a(3)	40
41	Occupational Therapy Consultant	138	5,775	Line 10a(3)	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	19	1,281	Line 11(3)	44
45	Social Service Consultant	42	2,721	Line 12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	511	$ 33,312		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides				52
53	TOTAL (lines 50 - 52)		$		53

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Shirley Axelbaum	Administrative	30.58	$ 9,580
Sue Burgin	Administrator	0	68,203
Una Tarpley	Asst. Admin.	0	20,067
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 97,850

B. Administrative - Other

Description	Amount
Management Fees (eliminated in column 7)	$ 146,057
TOTAL (agree to Schedule V, line 17, col. 3)	$ 146,057
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Cunningham Accounting	Accounting	$ 25,329
BKD, LLP	Accounting	6,000
Stone Carlie & Co.	Accounting	4,030
Weber & Hahn	Legal	2,081
Rosenblum, Goldennersch	Legal	777
Alliance Benefit Group	401k Consulting	1,660
Various	Accounting	2,295
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 42,172

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 55,336
Unemployment Compensation Insurance	43,246
FICA Taxes	250,456
Employee Health Insurance	173,968
Employee Meals	5,681
Illinois Municipal Retirement Fund (IMRF)*	
Employee Morale	36,564
Other Employee Benefits	172,440
Employer 401k Contributions	5,654
Payroll Taxes	
Home Offcice Allocation	22,745
TOTAL (agree to Schedule V, line 22, col.8)	$ 766,090

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	374
Health Care Worker Background Check	852
(Indicate # of checks performed 71)	
Illinois Health Care Assn. Dues	8,089
Other Dues	1,496
Various Books & Subscriptions	1,027
Quality Assurance	100
Licenses	400
Mgmt Co. Allocation: Licenses	616
Less: Public Relations Expense	(734)
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 12,220

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	2,116
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 2,116

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 Report Period Beginning: 01/01/02 Ending: 12/31/02

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Burgin Manor of Olney, Inc. # 0026765 **Report Period Beginning:** 01/01/02 **Ending:** 12/31/02

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **IHCA $8823.70**

(3) Did the nursing home make political contributions or payments to a political action organization? **Yes** If YES, have these costs been properly adjusted out of the cost report? **Yes**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? _____

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **7 yrs**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **34,345** Line _____

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. _____

(9) Are you presently operating under a sublease agreement? _____ YES **x** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES _____ NO **x** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

_____

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **83,767**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **Yes** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **0** Has any meal income been offset against related costs? **No** Indicate the amount. $ _____

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? **Yes**
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? **No** If YES, please indicate the amount of income earned from such a program during this reporting period. $ _____
c. What percent of all travel expense relates to transportation of nurses and patients? **21**
d. Have vehicle usage logs been maintained? **Yes**
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ _____

(17) Has an audit been performed by an independent certified public accounting firm? **No**
Firm Name: _____ The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? _____ If no, please explain. _____

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fees.